Name:_____ DOB: _____
SSN: _____ Cell:_____ **Patient Medical History Questionnaire**
Home:_____ Work: _____
Email:_____ Date: _____

Are you: □Single □Married □Divorced □Widowed □Domestics same-sex partner

GYNECOLOGIC HISTORY: (PLEASE MARK ALL THAT APPY)

If still menstruating: Duration of flow (days)_____Frequency of cycle _____ Age at first period _____
Date of last menstrual period_____ if postmenopausal, age at menopause_____
Date of last Mammogram_____ Colonoscopy_____Bone Density Test_____
Abnormal Pap/Dysplasia treatment and date:_____
Current Birth Control:
□Birth Control Pills □Depo-Provera □Nuva Ring □Condoms □Tubal Ligations □Vasectomy □Abstinence
Include date for: □Mirena IUD_____ □ ParaGard IUD_____ □Implanon_____ □Essure _____
□Endometriosis □Infertility □Fibroids □Genital Herpes □Gonorrhea □Chlamydia □Pelvic Inflammatory Disease
□HIV □HPV/Genital Warts □Syphilis

PREGNANCIES:

Total pregnancies _____ Full term deliveries____Premature deliveries____ Miscarriages ____Abortions ____Ectopic____
Living____

Date	Weeks at delivery	Length of labor	Birth Weight	Vag/C-Section	Gender	Place of Delivery	Complications

MEDICATIONS-INCLUDING VITAMINS, HERBS, OVER THE COUNTER (LIST NAME, DOSE, AND FREQUENCY)

1._____ 4. _____ 7. _____
2._____ 5. _____ 8. _____
3._____ 6. _____ 9. _____

DRUG ALLERGUES AND ADVERSE REACTION: _____
_____

PAST OR CURRENT MEDICAL HISTORY (CONDITIONS ARE CURRENTLY OR HAVE BEEN TREATED): □None

□Anemia _____
□Anesthesia Complication _____
□Anxiety Disorder _____
□Asthma _____
□Birth Defects/Inherited Diseases _____
□Blood clot in your veins or lungs_____
□Breast Cancer _____
□Colon Cancer _____
□Depression_____
□Diabetes_____
□Epilepsy, seizures, neurologic problems _____
□Gastrointestinal Problems _____
□High Cholesterol _____
□Headaches or Migraines_____
□Other_____

□Heart Condition _____
□Heart Disease _____
□Hepatitis _____
□High Blood Pressure_____
□Kidney Disease _____
□Kidney or bladder problems _____
□Malignant Melanoma _____
□Osteopenia _____
□Osteoporosis _____
□Ovarian Cancer_____
□Other Cancer_____
□Psychiatric Illness _____
□Thyroid Problems _____
□Uterine/Endometrial Cancer_____
□Vitamin D deficiency _____

Is a blood transfusion acceptable in an emergency? □ Yes □No
Have you ever received a blood transfusion? □Yes □No

SURGICAL HISTORY: (MARK ALL THAT APPLY AND DATE SURGERY PERFORMED) □No Surgeries

□Abdominoplasty _____
□Appendectomy (appendix)_____
□Bariatric (gastric bypass)_____

□Breast Biopsy_____
□Breast Implants _____
□Lump removed from breast _____

Name: _____ DOB: _____

□Cholecystectomy (gallbladder) _____
□Multiple abdominal surgeries _____
□Dilation & Curettage (D&C) _____
□Ectopic Pregnancy _____
□Endometrial Ablation _____
□Hysteroscopy _____
□Laparoscopy for _____
□Laparotomy (abdominal exploration) _____
□Hysterectomy by:
- □Laparoscopic removal of uterus without removal of cervix _____
- □Laparoscopic removal of uterus and cervix _____
- □Abdominal removal of uterus without removal of cervix _____
- □Abdominal removal of uterus and cervix _____
- □Vaginal hysterectomy _____

□Mastectomy _____
□Thyroid Surgery _____
□LEEP/Cone Biopsy _____
□Myomectomy _____
□Ovary Removal: □Both____ □Left___ □Right____
□Ovarian cyst removed _____
□Tubal Ligation _____
□Tube removed: □Both____ □Left___ □Right___

□Cesarean section(s) _____
□Other: _____

FAMILY HISTORY: (INDICATE WHICH RELATIVE AND MATERNAL/PATERNAL SIDE):

□No breast, gynecologic, colon cancer or malignant melanoma
□Anemia _____
□Anesthesia Complication _____
□Anxiety Disorder _____
□Asthma _____
□Birth Defects/ Inherited Diseases _____
□Blood clot in your veins or lungs _____
□Breast Cancer _____
□Colon Cancer _____
□Depression _____
□Diabetes _____
□Epilepsy, seizures, neurologic problems _____
□Gastrointestinal Problems _____
□High Cholesterol _____
□Headaches or Migraines _____
□Other _____

□Heart Condition _____
□Heart Disease _____
□Hepatitis _____
□High Blood Pressure _____
□Kidney Disease _____
□Kidney or bladder problems _____
□Malignant Melanoma _____
□Osteopenia _____
□Osteoporosis _____
□Ovarian Cancer _____
□Other Cancer _____
□Psychiatric Illness _____
□Thyroid Problems _____
□Uterine/Endometrial Cancer _____
□Vitamin D deficiency _____

SOCIAL HISTORY:

Occupation/Employer: _____
Have you ever been sexually active? □No □Yes: Age at first intercourse_____ Number of lifetime partners_____
Number of current sexual partners_____ Protected sex? _____ Oral sex?_____
Partner preference: □ Male □Female □Both
Smoking Status: Never Smoked Former smoker, quite when_____ Current smoker: How many a day? _____
Do you drink alcohol? Amount and frequency_____ Have you had problems with alcohol? □YES □NO
Do you currently use or used in the past street drugs? □Marijuana □Cocaine □Heroin □Narcotic Dependence
□Methamphetamines □Hallucinogens □Other_____
Have you experiences: □ Domestic abuse? _____ □ Sexual abuse?_____
□ Physical abuse? _____ □ NONE?
Primary Care Physician: _____
Patient Pharmacy: _____ Pharmacy Location/Phone #: _____